i ´		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155089	B. WIN			06/13/2014
NAME OF F	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE	
HEDITA	GE HOUSE OF NEV	N CASTI E			20TH ST ASTLE, IN 47362	
					7.01LL, IN 47.002	T
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
F000000	REGUERTIONT ON	Edge Id Elivin Tilvo II vi oravili Tilvo		1.10		Bitts
	This visit was fo	r a Recertification and	F00	0000		
	State Licensure S	Survey.			Defeciency ID: F _ 0000	
					Completion Date: July 13, 20	14
	Survey dates: Ju	ne 9, 10, 11, 12 & 13,			Completion Date: July 10, 20	17
	2014				Plan of Correction	
	Facilita o out	000025			F0000	
	Facility number:					
	Provider number AIM number: 10				Preparation and/or execution	
	Alvi number: 10	00266230			This Plan of Correction in general or any corrective action set for	
	G				herein, in particular, does not	ui
	Survey team:	J. T.C.			constitute an admission or	
	Leslie Parrett RN				agreement by Heritage House	
	Angel Tomlinson				New Castle of the facts allege the conclusions set forth in the	
	Barbara Gray Ri				statement of deficiencies. The	
	Diana Sidell RN				Plan of Correction and specific	
	C 1 . 1				corrective actions are prepare	
	Census bed type SNF/NF: 50				and/or executed solely becaus of provisions of federal and/or	
					state laws. Heritage House	
	Total: 50				desires this Plan of Correction	to
	Conque never +	no:			be considered the facility's	
	Census payor ty	μ <del>c</del> .			Allegation of Compliance.  Compliance is effective July 13	3
	Medicare: 5 Medicaid: 40				2014.	<u>,</u>
	Other: 5					
	Total: 50					
	10tai. 30				This building respectfully requ	ests
	These deficienci	es reflect state findings			consideration for paper	
		nce with 410 IAC			compliance from the Plan of	
	16.2-3.1.	ICC WILLI TIV IAC			Correction.	
	10.2-3.1.					
	Ouality review c	completed on June 19,				
	2014 by Cheryl	•				
	2011 by Chery1	. 1010011, 1011.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/13/2014		
	PROVIDER OR SUPPLIE GE HOUSE OF NE			1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F000225 SS=D	have been found neglecting, or mis court of law; or ha into the State nurs abuse, neglect, m misappropriation any knowledge it law against an emindicate unfitness or other facility staregistry or licensing. The facility must eviolations involvin abuse, including i and misappropria are reported immediate administrator of the officials in accordithrough established the State survey at alleged violations investigated, and potential abuse with progress.  The results of all in reported to the addesignated represofficials in accordinctly in according to the State survey at a survey	EPORT NDIVIDUALS not employ individuals who guilty of abusing, treating residents by a treating residents by a treating residents by a treating residents or the se aide registry concerning istreatment of residents or the se of actions by a court of aployee, which would for service as a nurse aide aff to the State nurse aide and authorities.  The surrent that all alleged go mistreatment, neglect, or an injuries of unknown source tion of resident property rediately to the the facility and to other ance with State law red procedures (including to and certification agency).  The ave evidence that all are thoroughly must prevent further thile the investigation is in the sentative and to other ance with State law red procedures of the sentative and to other ance with State law red procedures of the sentative and to other ance with State law					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 2 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	A. BUILDING 00			COMPLETED	
		155089				06/13/2014		
			B. WIN		ADDRESS SITE STATE SID CODE			
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE			
LIEDITA	25 HOUSE OF NE				20TH ST			
HERITAG	GE HOUSE OF NEV	W CASTLE		NEW C	ASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	verified appropriat	te corrective action must						
	be taken.							
	Based on intervi	ew and record review the	F00	0225	Heritage House will continue		07/13/2014	
	facility failed to	report an allegation of			ensure that all alleged violation			
		ninistrator immediately			of verbal abuse are thoroughly			
		loyee continuing to work			investigated and prevent furthe	er		
					potential abuse while the investigation is in process. All			
		on and delayed the			allegations of abuse will be			
	_	the allegation of abuse			reported to officials in accorda	nce		
	for 1 of 3 resider	nts reviewed for abuse			with State Law. 1. The alleged			
	(Resident #1).				incident of verbal abuse was			
					reported to the DON and			
	Finding include:				Administrator on 6/10/14 and t	-		
	i mama meraus.				the surveyors on 6/11/14. The	;		
	I4	0.5.i.d. 11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1			allegation of abuse was			
		Resident #1 on 6/11/14 at			thoroughly investigated when			
	· ·	cated CNA #10 did not			reported to the DON on 6/10/1	4.		
	treat her good an	nd was rude to her. When			CNA #10 was immediately suspended pending the			
	queried what did	I CNA #10 do that she			investigation and was still on			
	felt was rude, Re	esident #1 indicated CNA			suspension when the surveyor	s		
	#10 would tell th	ne resident if she did not			were notified. 2. Any resident			
	like the way she	did her care she would			making an allegation of verbal			
	1	at and not give her care.			abuse has the potential to be			
		•			affected. All residents making			
		cated CNA #10 would			any type of allegation of allege			
	tell her when she	e was giving her			verbal abuse will be reported t	0		
	incontinence car	e if she did not like the			the appropriate officials in	A 11		
	way she cleaned	her up she would leave			accordance with State law. 3. staff will be inserviced on the	AII		
	the resident wet.	Resident #1 indicated			proper reporting of allegations	of		
		A #10 to the Director Of			abuse by7/13/2014. All new hi			
		and she felt like it was			will be educated on abuse			
					prohibition and proper reportin	g.		
		esident #1 indicated CNA			4. All accusations of abuse wil	•		
	#10 was no long	er allowed to give her			investigated and reported to the	ie		
	care.				appropriate State agencies.			
					Attachment #1. The DON or			
	Interview with C	CNA #1 on 6/11/14 at			designee will monitor reportab	le		
		cated she was giving			log weekly for 3 months then	•		
	12.57 P.111., III.	Jacob Dire Was Biving			monthly for 3 months to ensure	=		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 3 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089		LDING	00	(X3) DATE : COMPL <b>06/13</b> /	ETED
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE 20TH ST	•	
HERITAC	SE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
TAG	Resident #1 a bar resident reported was rude and hat indicated the resident CNA #10 we come back to give come back and versident care. CN reported the alleg 5/31/14. When query the date of this in indicated she know last weekend she last weekend she last weekend she last weekend she wo care without ano CNA #10 indicated sh	th on 5/31/14 and the to her that CNA #10 reful to her. CNA #1 ident also reported to her could tell her she would be her care and then not would refuse to give the NA #1 indicated she gations to RN #2 on ueried how did she know neident, CNA #1 rew because it was the had worked.  ENA #10 on 6/11/14 at ted Resident #1 had since her employment uary 2014. CNA #10 ruld not give Resident #1 ther staff person present. The Resident #1 would refuse to position her pillow the did not do it #10 indicated she had of mean to Resident #1, resident mistreated her.  Resident #1 on 6/12/14 at reated she reported to or two ago that CNA did hateful to her. Resident A #1 was cleaning her up red CNA #10 to her.		TAG	compliance. These reportable will be reported to the QA Committee and recommendations followed.		DATE
1	Resident #1 man	cated she did not know if					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 4 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  IDENTIFICATION NUMBER:  155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 06/13/2014				
	PROVIDER OR SUPPLIER GE HOUSE OF NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST  NEW CASTLE, IN 47362						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				
	CNA #1 reported it to the nurse. Resident #1 indicated no other nurse besides the DON had talked with her about the incident.							
	Interview with the DON on 6/12/14 at 1:30 p.m. indicated on 6/10/14 Resident #1 reported to her that CNA #10 was mean to her and yelled at her. The DON indicated CNA #1 did not report that Resident #1 had complained to her about CNA #10 until 6/11/14. The DON indicated CNA #1 told her she reported the allegation to RN #2.							
	Interview with RN #2 on 6/12/14 at 3:07 p.m., indicated no staff had reported any allegations of abuse related to Resident #1. RN #2 indicated CNA #10 reported to her that Resident #1 was mean and nasty to her. RN #2 indicated CNA #10 would not give Resident #1 care without another staff person present. RN #1 indicated CNA #10 would answer Resident #1's call light and would let her know when another staff member was available to assist her she would give her care.							
	Interview with the Administrator on 6/12/14 at 3:48 p.m., indicated RN #2 or CNA #1 had reported any allegations of abuse to her related to Resident #1 or CNA #10. The Administrator indicated							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 5 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI <b>06/13</b>	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST  NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	on 6/10/14 related CNA #10 by the Administrator in reported an alleg yelled at Resider indicated CNA # to work until the completed.  Review of the re 6/12/14 at 11:00 resident's diagnor not limited to, m pain, dementia w seizures.  The Quarterly M assessment dated following: Brief Status (BIMS) so impaired, bed me assistance of two activity did not continued activity did not continued assistance of two extensive assist							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 6 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  06/13/2014				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST  NEW CASTLE, IN 47362						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	indicated CNA # 5/31/14 when Reallegation of abu	A schedule as worked 10 worked 5 days after esident #1 reported the se.							
	Administrator or indicated if any a voiced an investi "Should an occur behavior be repo	a 6/11/14 at 10:06 a.m. allegation of abuse are gation will be initiated. rrence of abusive rted or witnessed, the ad Director Of Nursing							
	alleged violation investigated by t his/her designee. prevent further p investigation is i	immediately." "The shall be thoroughly he Administrator or "The facility must otential abuse while the process." "For vidual who has been							
	alleged as exhibition should not be percare for residents	ting abuse behavior rmitted to continue to suntil an investigation ted and the allegation							
	3.1-28(a)								
F000226 SS=D	ETC POLICIES	ENT ABUSE/NEGLECT, evelop and implement							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 7 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00			ETED
		155089	B. WIN			06/13/	2014
			J. (711)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	2			20TH ST		
HERITAC	GE HOUSE OF NEV	W CASTLE			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	d procedures that prohibit					
		llect, and abuse of appropriation of resident					
	property.	appropriation of resident					
		ew and record review the	F00	0226			07/13/2014
	facility failed to	implement the policy of			F226 Heritage House will contin		
	abuse by not pro	tecting residents,			to develop and implement writ	ten	
		investigation and			policies and procedures that prohibit mistreatment, neglect		
	1	gation of verbal abuse			and abuse of residents and	'	
	1 0	of 3 residents reviewed			misappropriation of resident		
	for abuse/neglec				property. 1. This allegation of		
	Tor double filegies	t (Resident #1).			verbal abuse made by resider		
	Finding include:				re: CNA #10 was reported to t DON and Administrator on	ne	
	Tillding merude.				6/10/14. CNA #10 was		
	I4	0.5.1.4.4.1 5.4 6/11/14.54			immediately suspended pendi	ng	
		Resident #1 on 6/11/14 at			the investigation. A		
	· ·	cated CNA #10 did not			thorough investigation was do		
	_	nd was rude to her. When			on the allegation of alleged ve		
	•	I CNA #10 do that she			abuse made by resident # 1, t allegation was not substantiate		
	, , , , , , , , , , , , , , , , , , ,	esident #1 indicated CNA			2. Any resident who makes ar		
	#10 would tell th	ne resident if she did not			allegation of verbal abuse has		
	like the way she	did her care she would			potential to be affected. All		
	leave the residen	at and not give her care.			resident allegations were	•	
	Resident #1 indi	cated CNA #10 would			reviewed for the last 6 month. resident allegations of any typ		
	tell her when she	e was giving her			abuse will be reported to the	e oi	
		e if she did not like the			appropriate State agencies wi	thin	
		her up she would leave			24hours of the incident and ar		
	_	Resident #1 indicated			investigation will be done on a	II	
		A #10 to the Director Of			allegations. 3. All resident	_	
	_	and she felt like it was			allegations of any type of abus will be reported to the appropr		
	• • •	esident #1 indicated CNA			State agencies within 24hours		
					the incident and an investigati		
		er allowed to give her			will be done on all allegations.		
	care.				See attachment #2. All staff w	ill	
					be inserviced on abuse by		
		CNA #1 on 6/11/14 at			7/13/14. 4. The DON or her designee will monitor all ISDH		
	l 12·39 n m india	eated she was giving			L designee will infollitor all ISDIT		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 8 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	E SURVEY PLETED 3/2014
	PROVIDER OR SUPPLIER		1023 N	ADDRESS, CITY, STATE, ZIP CO 20TH ST CASTLE, IN 47362	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	resident reported was rude and hat indicated the rest that CNA #10 w come back to give come back and w resident care. Che reported the alleges 5/31/14. When quantities the date of this in indicated she know last weekend she wo care without ano CNA #10 indicated with a week #10 was rude and #1 indicated CNA when she reported when she	ew because it was the chad worked.  ENA #10 on 6/11/14 at atted Resident #1 had since her employment uary 2014. CNA #10 buld not give Resident #1 ther staff person present. Ited Resident #1 would for to position her pillow		reportables weekly for then monthly for 3 mon Social Service Director designee will monitor a complaints/concerns/gr weekly for 3 months. Findings reported to the QA Correview and recommence be followed. All staff with inserviced on abuse by	oths.  or  ill  rievances  ad monthly  will be  mmittee for  dations will  ll be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 9 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI <b>06/13</b>	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1023 N 20TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	#1 indicated no	I it to the nurse. Resident other nurse besides the with her about the						
	1:30 p.m. indicat #1 reported to he mean to her and indicated CNA # Resident #1 had CNA #10 until 6	ne DON on 6/12/14 at ted on 6/10/14 Resident or that CNA #10 was yelled at her. The DON of 1 did not report that complained to her about 1/11/14. The DON of 1 told her she reported RN #2.						
	p.m., indicated n allegations of ab #1. RN #2 indicato to her that Residenasty to her. RN would not give F another staff persindicated CNA # Resident #1's cal know when anot	N #2 on 6/12/14 at 3:07 o staff had reported any use related to Resident ated CNA #10 reported ent #1 was mean and #2 indicated CNA #10 Resident #1 care without son present. RN #1 10 would answer 1 light and would let her her staff member was at her she would give her						
	6/12/14 at 3:48 p CNA #1 had repart abuse to her rela	ne Administrator on o.m., indicated RN #2 or orted any allegations of ted to Resident #1 or administrator indicated						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 10 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155089	B. WIN			06/13/	2014
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
HERITΔ(	GE HOUSE OF NE\	N CASTI F			20TH ST ASTLE, IN 47362		
					AOTEE, IIV 47002		(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		abuse was reported to her					
	_	ed to Resident #1 and					
	CNA #10 by the DON. The						
	1	dicated the DON					
		gation that CNA #10					
		nt #1. The Administrator					
	l *	\$10 was told not to report					
		investigation was					
	completed.						
	•						
	Review of the re	ecord of Resident #1 on					
		a.m., indicated the					
		oses included, but were					
		aild retardation, obesity,					
		vith behaviors and					
	seizures.						
	The Quarterly M	Iinimum Data Set (MDS)					
		d, 5/8/14 indicated the					
		Interview for Mental					
		core was 11- moderately					
	impaired, bed m	obility- extensive					
	_	people, transfer-					
		occur, walk in room-					
	1	occur, dressing- extensive					
	_	people, toileting-					
		ance of two and personal					
		ve assistance of one.					
	Review of the nu	ursing and cna schedule					
		ded by the DON on					
		d RN #2 and CNA #1					
	worked together	on day shift on 5/31/14.					
		work the weekend after					
	l						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 11 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAIN	OF CORRECTION	155089	A. BUII	LDING	00	06/13/	
		100008	B. WIN			00/13/	ZU 1 <del>'1</del>
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HOUSE OF NEV	V CASTLE			20TH ST ASTLE, IN 47362		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		A schedule as worked					
		10 worked 5 days after					
		esident #1 reported the					
	allegation of abu	se.					
	The abuse policy provided by the						
	Administrator or	n 6/11/14 at 10:06 a.m.					
		allegation of abuse are					
		gation will be initiated.					
	"Should an occur	rrence of abusive					
	behavior be repo	rted or witnessed, the					
	Administrator an	d Director Of Nursing					
	shall be notified	immediately." "The					
	alleged violation	shall be thoroughly					
	investigated by the	he Administrator or					
	his/her designee.	" "The facility must					
	prevent further p	otential abuse while the					
	investigation is in	n process." "For					
	example, an indi	vidual who has been					
	alleged as exhibi	ting abuse behavior					
	should not be per	rmitted to continue to					
	_	s until an investigation					
		ted and the allegation					
	found to be unsu	_					
	3.1-28(a)						
F000282	402 20(k)/2)/;;)						
SS=D	483.20(k)(3)(ii) SERVICES BY QU	JALIFIED PERSONS/PER					
30-D	CARE PLAN	J ILD I LIKOOHON LIK					
		ided or arranged by the					
	facility must be pro						
	persons in accorda written plan of care	ance with each resident's					
	willen plan of Care	<del>5</del> .	I	Ţ			l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 12 of 33

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
		155089	A. BUII		· ·	06/13/	2014
			B. WIN				_
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAC	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
			F00	0282	Heritage House will continue t		07/13/2014
	Based on observ	vation, interview and			provide or arrange for services	s to	
	record review the facility failed to follow the care plan for Dental Services for 1 of				be provided to residents by		
					qualified persons in accordance		
	_				with each residents care plan.		
		met the criteria for Dental			Resident #53 has been seen b	•	
	Services. (Resid	ent # 53)			the dentist on both 6/18/14 an 6/26/14. Impressions have be		
					made for replacement lower	CII	
	Findings include	2.			dentures. Resident #53 has ha	ad	
					his care plan revised and upda		
	Dagidant absorre	ation on 6/9/14 at 9:10			to include current plans to ens		
					resident is seen by the provide		
	· ·	Resident # 53 was in his			while he is awake. 2. Any resi		
	room lying in be	ed with eyes open, when			who had a care plan that state		
	this writer appro	pached Resident for			they have a history of refusing	ı	
		sed his eyes and would			ancillary services due to their		
	not respond.	ou mo ey es uma weara			refusal to get up and allow		
	not respond.				service provider to see them.		
		777 // 4 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 /			Care plans will be review and		
		LPN # 4 on 6/9/14 at 9:20			revised as needed for all		
	p.m., indicated I	Resident # 53 does not			residents with the same identi		
	like to be bother	red while he's in bed for			problem by 7/13/14. 3. Staff w be inserviced on the timely	''''	
	his nap.				reporting of the need for ancill	arv	
					service for the residents. A	ary	
	Observation on	6/9/14 at 11:40 a.m. of			new ancillary services request	ŀ	
					form has been developed.		
		dicated he was up in his			Attachment #3. All resident ca	are	
	room and was pl	leasantly confused and			plans re: ancillary services wil	l be	
	not interviewabl	e.			reviewed and revised as need	ed	
					by 7/13/14. 4.All requests for		
	On 6/10/14 at 9.	41 a.m., an interview			ancillary services will be		
		•			reviewed and the residents na	ime	
	with Resident # 53's daughter indicated				added to the list to see the needed ancillary services		
	Resident lost his lower denture at the facility in December and denture has not been found or replaced at this time.				provider. The Social Services		
					Director or their designee will		
					review the requests weekly for	<sub>r 3</sub>	
	Daughter indica	ted she told "one of the			months then monthly for 3		
	girls" does not re	emember the name of			months. This information		
	~	ied of missing dentures.			will be reported to the QA		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155089	B. WIN			06/13/	2014
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		1023 N	20TH ST		
	GE HOUSE OF NEV				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	Committee and		DATE
		nurse I believe it was a			recommendations followed.		
		she would notify laundry			recentifications renewed.		
	so they would lo						
	someone would let me know if they were found or not. No one has gotten back						
	with me about his dentures and I don't						
	know if they hav	ve made a dental					
	appointment for	him yet."					
	Review on 6/11/	/14 at 10:15 a.m., of					
	Resident # 53's r	record indicated dental					
	services oral ass	essment forms on					
	2/11/14 and 3/12	2/14, which indicated					
		fused dentures on those					
	dates.						
		lent # 53's inventory					
		Resident had upper and					
	lower dentures of						
	lower dentares o	on admission.				ļ	
	On 6/13/14 at 11	1:15 a.m., an interview					
	with the Social S	Services Director					
	indicated she wa	as notified on 2/10/14,					
		ed me Resident # 53's					
	1	as missing. I was not					
		daughter notified me on					
		l him on the list to be					
	_	ist the next day which					
	was 2/11/14."	me men any minon					
		or lost items is I start a					
	-	an item is not found the					
	· ·						
		ace clothing, money, te that but if it's dentures					
	1	e go through services					
	such as medicaio	d. We try to replace items				ļ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 14 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		OO OO	(X3) DATE COMPI	LETED	
		155089	B. WING			06/13	/2014
	PROVIDER OR SUPPLIER		10	)23 N 2	DDRESS, CITY, STATE, ZIP CODE OTH ST STLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	medicaid. "When I was tall services person, medicaid and he enroll in the progprior authorization weeks." "Resident # 53 with the dentist was had 3/12/14, I'm sure dental services a like to be disturb. Social Services I was in the dining meal when Reside asked him if he will denture and Residentures and Residentures and Residentures. When he had ancillary service up and allow ser Goal: Residents review every 90 Approach: 1. All when he wishes, him if he would 2. Approach with	sident indicated yes, he we them for eating.  :45 a.m., Social Services blan for dental services dicated: nt likes to get up on his s a history of refusing s due to his refusal to get vice provider to see him. care needs will be met,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 15 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155089	B. WIN	G		06/13/2	2014
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAC	GE HOUSE OF NEV	N CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION  PROVIDER'S PLAN OF CORRECTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	-	DATE
	_	to have provider explain					
	to the Resident why he is here and what he wants to help with. If feasible, have the Resident seen in his room where he is						
	at.	1105 11 1 1					
		d if Resident is already					
	* '	en at that time before he					
	goes back to his	room.					
	Intomia	2/14 -4 2.15					
		3/14 at 2:15 p.m., with					
		or indicated "I was not					
		lent # 53 losing his lower					
		oruary when his daughter					
		al Services Director. An					
		ort was done as soon as I					
	was notified." A	dministrator indicated					
	Resident # 53 w	ould be placed on dental					
	schedule for den	tal services visit next					
	week on 6/18/14	<b>.</b>					
		30 p.m., interview with					
		Director indicated no she					
		Resident # 53 was					
	_	er denture until February					
	and no dentures	had been found in the					
	laundry.						
		(14 . 0.45					
		14 at 2:45 p.m., of					
	_	y Concern Form provided					
	•	rator dated 2/10/14					
		ent # 53's daughter states					
		nissing his bottom					
	denture - fears th	nat he has thrown them in					
	the trash - (been	missing for a while -					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 16 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED			
ANDILAN	or connection	155089	A. BUII			06/13/			
		100000	B. WIN		PRESIDENCE CONTROL CON	00/10/	2014		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST						
HERITAC	GE HOUSE OF NEV	V CASTLE	NEW CASTLE, IN 47362						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION		
TAG		would " turn up."		TAG	Birchivery		DATE		
		en referred to dental							
		to be seen tomorrow.							
		d 2/27/14 Resident							
	_	ed the dentist when he							
		be placed on the list for							
	next visit.	piacou on the fist for							
	110/110 110/11.								
	On 6/13/14 at 2::	50 p.m., Policy for lost							
		vas provided by the							
	Director of Nurs								
		Following investigation,							
	it shall be at disc	retion of the							
	Administrator as	to replacement of lost or							
	stolen items base	ed upon individual							
	circumstances.								
	3.1-35(g)(2)(1)								
F000323	483.25(h)								
SS=D	FREE OF ACCIDE								
		RVISION/DEVICES Insure that the resident							
		ins as free of accident							
		sible; and each resident							
	receives adequate								
	assistance devices	s to prevent accidents.	FUU	0323	F323 Heritage House will		07/13/2014		
			1.00	0323	. ozo monago modoc wiii		07/13/2014		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 17 of 33

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155089	A. BUIL B. WING			06/13/	2014
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LIEDITA/	GE HOUSE OF NE	ALCASTI E			20TH ST ASTLE, IN 47362		
ПЕКПА	JE HOUSE OF INE	W CASTLE		INEVV C	ASTLE, IN 47302		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on observ	ration, record review, and			continue to ensure that the		
	interview, the facility failed to ensure a				resident environment remains	as	
	dependent resident was free from				free of accident hazards as is possible; and that each reside	nt	
	accidents in that one resident was left				receives adequate supervision		
	unattended with her breakfast tray,				and assistance devices to pre		
		•			accidents. 1. Resident #3 will		
	-	hot water on herself and			be left unattended with her me		
		degree burns. This			tray that contains hot beverag	es.	
		esidents affected in a			2. All residents who require		
	sample of 4 revi				assistance with meals and		
	accident/hazards. (Resident #3)				choose to drink hot	to	
					beverages have the potential be affected. All dependent	ιο	
	Findings include:				residents who requires assista	ance	
					with meals will not have their		
	Resident #3's rea	cord was reviewed on			trays that contain hot liquids le		
					in their rooms when not being		
		p.m. The record			3.All dependent residents will		
		ent #3 was admitted with			have their food trays, that con		
	diagnosis that in	cluded, but were not			hot beverages, left in their roo		
	limited to, high	blood pressure, type two			when not being fed. An Eating	3	
	diabetes, angina	, dementia, pain, anxiety,			Assistance Log has been developed and all residents		
	depression, Alzh	neimer's disease, and			needing assistance will be		
	cellulitis.	,			monitored to ensure that no fo	ood	
					trays containing hot beverage		
	A questarly Min	imum Doto Cot			are being left in the room whe	n	
	A quarterly Min				the resident is not being fed. A		
		OS), dated 2/7/14,			staff to be inserviced by 7/13/	14.	
		ent #3 was severely			4. Nursing Dept. will keep		
	impaired, never/	rarely made decisions in			an Eating Assistance Log on a		
	cognitive skills	for daily decision			residents requiring assistance with their meals to ensure that		
	making, and req	uired extensive			resident trays containing hot	•	
	assistance of one				beverages are not left in resid	ent	
		<b>G</b> -			rooms when the resident is no		
	A quarterly MD	S, dated 5/20/14,			being fed. Attachment #4. The		
					DON or her designee will mor		
		ent #3 was severely			log 5 times a week for 3 mont	hs,	
		rarely made decisions in			1 time a week for 3 months.		
	cognitive skills	for daily decision			Findings will be reported to the	е	

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155089	B. WIN			06/13/2	2014
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIEDITAC		N CACTLE			20TH ST		
	GE HOUSE OF NEV			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG	making, and required extensive		+	TAG	QA committee and		DATE
	1				recommendations followed.		
	assistance of one	e for eating.					
	37 1 1	1.6/5/14 0.20					
		ted 6/5/14, at 8:30 a.m.,					
		dent found [with] cup of					
		n bed to left hip, lid in					
	1 * *	orted to this nurse. CNA					
		dent if it hurt, resident					
	stated "no it's ok	ay."					
		1 . 1 . (4/4 4					
		ogress note dated 6/4/14,					
	_	thot coffee on skin, 2					
	"	burns, blister popped,					
	neosporin applie	d"					
		from [local physician's					
		10/14, and signed by a					
	_	r, indicated: "Chronic					
	_	from hot water spill last					
	` ′ *	aving been using					
	neosporin oint (o						
		burning. (L) hip [with]					
	` `	ntimeter) dia[meter] area					
	^	with] moderate amt					
	l ` ′ ′ •	llow slough & peeling					
		Burn periphery [with]					
	narrow band ery	, ,					
	_	lan: 2nd degree burn (L)					
	hip, switch to sil	vadene, monitor"					
		hone orders, dated					
	6/5/14, indicated	: "Apply Neosporin plus					
	to left hip areas l	BID (twice a day) x 10					
	days."						
	1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 19 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155089			LDING	NSTRUCTION 00	(X3) DATE COMPL 06/13/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST  NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	Physician's telep 6/10/14, indicate burn, start silvad (every day). Ind (L) hip."  A care plan for "breakdown" date goal: "Will have d (days). Approx (every) shift for symptoms) of potential (E.G. redness/disareas). Alert chanotification of plobtain TX (treath lotion to skin 2X exposure to hot viceansing agent a minimize irritate skin17. Apply hip area bid X 10 Monitor areas for 6-5-14. Notify Mandegree burn Silvadene et foar burn areas. 6-10-10 A care plan for "extensive to total (activities of daily contains the start of the st	hone orders dated d: "Stop neosporin to ene & foam dressing qd ication: 2nd degree burn  Potential for skin ed 4/24/14, indicated a no skin breakdown X 90 ach: (1) Monitor skin Q S/Sx's (signs and etential skin breakdown scoloration or open arge nurse if observed for nysician as needed to ment) orders. (2) Apply daily(8) Avoid water and use mild and gentle touch to on and dryness of neosporin plus to (L) od. [Discontinued] r s/sx's of infection, MD if appears worse to to (L) hip. 18. m dressing qd to (L) hip 14."  Res (resident) requires l assist with ADL'S		TAG			DATE	
		s wet with warm water						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 20 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089			LDING	NSTRUCTION  00	(X3) DATE COMPL 06/13/	ETED	
	PROVIDER OR SUPPLIER		р. үүн	1023 N	DDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	X90 d. Approace at times, allow herself, if unable Provide and encoroom when giving only have hot be supervision. 6-5-4. A Fax/Incident F8:10 a.m., indicated function of Incident: Rest with cup of hot with lid still intate how the cup got "I dropped my with hid still intate how the cup got "I dropped my whurt, resident state It's okay." Type blisters noted to cm X < 0.1 cm. Immediately functional forms and the cup into her limited the most of the cup into her limited measures taken: served hot bever the staff member her with breakfar resident out to the cup into the cup	hes10. Res requires fed er to attempt to feed e, staff to feed her. 12. burage fluids while in ag ADL care18. Pt will verages [with]		TAG	DEFICIENCY)		DATE
	indicated her tray	y was left at her bedside					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 21 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155089		LDING	NSTRUCTION 00	(X3) DATE COMPL <b>06/13</b> /	ETED	
NAME OF	PROVIDER OR SUPPLIEF	<u>.</u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HOUSE OF NE\	W CASTLE		20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and the resident bed with her and burned, but usual stay with her to nurse had left her from the resident reach for her tray of the room, they reach her tray and given her tray under the tray and given her tray under the tray and the other was observed for noon meal which hot beverages or the top layer of series and the other was both had open and the top layer of series and the deges.  A policy titled "to Prevent Accident of 1/10/13, Administrator of the resident was a series and the of 1/10/13, Administrator of the top layer of series and the top layer of series and the other was both had open and the top layer of series and the top lay	pulled the cup into the I that's how she was ally staff take her tray and feed her. She said the er tray about two feet t, and she usually doesn't ty, the nurse got called out ty didn't think she could and Resident #3 was never massisted.  2:47 a.m. CNA #5 d fed Resident #3 this cfast and she did not have les on her tray. CNA #5 leding Resident #3 the in also did not have any				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 22 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	COMPL	
ANDILAN	OF CORRECTION	155089	A. BUI	LDING	00	06/13/	
		133009	B. WIN			00/13/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HOUSE OF NEV	V CASTLE			20TH ST ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	·	efers to any unexpected					
		incident or chain of					
		y or may not result in					
		to a patient. This does					
		rse outcomes that are a					
	_	ice of treatment or care					
	*	rdance with standards of					
	*	ls may include but not					
	limited to aspect	s of physical plant,					
	equipment and d	evices that are defective					
	or are not used p	roperly (per					
	manufacturer spe	ecifications) are					
	disabled/remove	d or are not individually					
	adapted or fitted	to the patient needs.					
	Avoidable Accid	lent: Identify					
	environmental h	azards and individual					
	patient risk of an	accident including the					
	need for supervis	sion; and/or:					
	Evaluate/analyze	e the hazards and risk;					
	and/or: Impleme	ent interventions,					
	including adequa	ate supervision,					
	consistent with p	atient needs, goals, plan					
	of care and recog	gnized standards of					
	practice in order	to reduce the risk of an					
	accident; and/or:	Monitor the					
	effectiveness of	the interventions and					
	modify the appro	paches as necessary in					
	accordance with	relevant care standards.					
	Unavoidable Ac	cident: Identify					
		azards and individual					
	patient risk of an	accident, including the					
	need for supervis	_					
	•						
	3.1-45(a)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 23 of 33

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL 06/13/		
155089			B. WIN			00/13/	2014	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  20TH ST			
HERITAC	SE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE	
1710	3.1-45(a)(2)	ESC IDENTIFY TING INFORMATION)		1710	·		DATE	
F000412 SS=D	483.55(b) ROUTINE/EMERO SERVICES IN NET The nursing facility from an outside re with §483.75(h) of extent covered une emergency dental needs of each resi assist the resident and by arranging f from the dentist's or refer residents with dentures to a dent Based on observa record review the Care Plan interve services to meet residents that me services. (Reside Findings include Resident observa a.m., indicated R	y must provide or obtain source, in accordance this part, routine (to the der the State plan); and services to meet the ident; must, if necessary, in making appointments; for transportation to and office; and must promptly in lost or damaged ist.  aton, interview and e facility failed to follow entions to provide dental the needs of 1 of 4 of the criteria for dental ent # 53)	F00	0412	Heritage House will continue to provide or obtain from an outsi resource routine and emergen dental services to meet the ne of each resident; will if necess assist the resident in making appointments; and by arrangin transportation to and from the dentist's office; and will promp refer residents with lost or damaged dentures to a dentist Social Services was notified or 2/10/14 by resident #53 daughthat resident was missing his bottom denture and fears he had thrown them in the trash.	ide cy eds ary, g ttly t. 1. n tter	07/13/2014	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 24 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	TED
155089		155089	A. BUI B. WIN			06/13/2	014
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				20TH ST		
HERITA <i>(</i>	GE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362		
					T		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	44-	DATE
		ached Resident for			Resident #53 was added to lis be seen by the dentist on 2/11		
	interview he clos	sed his eyes and would			and again on 3/12/14. Resider		
	not respond.				53 refused to see the dentist b		
					times. Resident #53 was seen	I .	
	Interview with L	PN # 4 on 6/9/14 at 9:20			the dentist on both 6/18/14 and	-	
		Resident # 53 does not			6/26/14. Impressions have been	en	
		ed while he's in bed for			made for replacement lower		
		ca willie he s in ocu ioi			dentures. 2. Any resident who		
	his nap.				had the need for routine or	<sub>d</sub>	
					emergency dental services an refused to be seen for any	u	
		5/9/14 at 11:40 a.m. of			reason. A new Social Services	,	
	Resident # 53 in	dicated he was up in his			Referral Form has been		
	room and was pl	easantly confused and			developed and will be put into	use	
	not interviewable	e.			by 7/13/14. Attachment #3. Sc	ocial	
					Services will be required to		
	On 6/10/14 at 9:	41 a.m., an interview			schedule the needed ancillary		
		53's daughter indicated			services, address lost items or		
		lower denture at the			other concerns promptly. This depend on the availability of a		
					appointment with the needed	"	
	1	nber and denture has not			provider. 3. Staff will be		
		placed at this time.			inserviced on the timely		
	Daughter indicat	ed she told "one of the			reporting using the Social Serv	vice	
	girls" does not re	emember the name of			Referral Form and reporting of	f	
	person she notifi	ed of missing dentures.			lost items by 7/13/14. A		
	_	urse I believe it was a			new Social Services Referral		
		he would notify laundry			Form has been developed. Se attachment #3. See attachmen		
	so they would lo				#5 for policy on lost items. So	I .	
	1				services is to be notified prom		
		let me know if they were			of an emergency request for	r)	
		one has gotten back			services and/or lost items. So	cial	
		is dentures and I don't			Services or their designee will		
	know if they hav	re made a dental			address the issues indicated of		
	appointment for	him yet."			the forms and call the needed		
					ancillary services provider and	1	
	Review on 6/11/	14 at 10:15 a.m., of			schedule an appointment promptly, if indicated, dependi	na	
		ecord indicated dental			on the availability of an	''9	
		essment forms on			appointment. 4. All Social		
	i services urai assi	COSHICHT TOTHIS OH	- 1		''' '' ''' ''' ''' '''' ''''		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 25 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	۱ DI III	LDING	00	COMPL	ETED
		155089	A. BUII B. WIN			06/13/	2014
			J. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			20TH ST		
	GE HOUSE OF NEV			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· ·		DATE
		2/14, which indicated			Services Referral Forms or Resident Concern Form wil	l ho	
	Resident # 53 re	fused dentures on those			reviewed and the residents na		
	dates.				added to the list to see the		
	Review of Resid	lent # 53's inventory			needed ancillary services prov	rider	
	sheet indicated F	Resident had upper and			or other issues addressed		
	lower dentures o	n admission.			promptly. In the case of an		
					emergency the ancillary service provider will be called promptly		
	On 6/13/14 at 11	:15 a.m., an interview			and appointment made for the	, I	
		Services Director			resident to be seen. The Socia		
	indicated she wa	as notified on 2/10/14,			Services Department or their		
		ed me Resident # 53's			designee will review the Socia	ı	
	_	as missing. I was not			Services Referral Forms/	leh e	
		daughter notified me on			Resident Concern Forms wee for 3 months, then monthly for		
		I him on the list to be			months, to ensure appointmer		
	_				have been made appropriately		
	1	ist the next day which			and any lost items identified. T		
	was 2/11/14."	1			information will be reported to	the	
	_	r lost items is I start a			QA Committee and their recommendations followed.		
		an item is not found the			recommendations followed.		
	1	ace clothing, money,					
	smaller items lik	te that but if it's dentures					
	1	e go through services					
	such as medicaio	d. We try to replace items					
	if we can or use	resident services like					
	medicaid.						
	"When I was tall	king with the dental					
		they process it through					
	1 '	has to have liability to					
		gram or send a medicaid					
		on that could take up to 6					
	weeks."	tonia unite up to o					
		vas in bed napping when					
		here on 2/11/14 and on					
		e that is why he refused					
	dental services a	t that time, he doesn't					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 26 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
155089		B. WIN			06/13/2014		
NAME OF F	DROWNER OF GUIDNI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1023 N	20TH ST		
	GE HOUSE OF NEV			l	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		bed when he's napping."					
		Director indicated she					
	_	g on 6/12/14 for evening					
		dent # 53's daughter					
	asked him if he v						
	dentures and Res	sident indicated yes, he					
	would like to have	ve them for eating.					
	On 6/13/14 at 11	:45 a.m., Social Services					
		olan for dental services					
	dated 2/11/14 inc	•					
		nt likes to get up on his					
		s a history of refusing					
		s due to his refusal to get					
	<u> </u>	vice provider to see him.					
		care needs will be met,					
	review every 90						
	Approach: 1. All	low Resident to get up					
	when he wishes,	but always return to ask					
		like to see the provider.					
	2. Approach with	h alternate caregiver.					
	3. If provider is	willing and has the					
	_	o have provider explain					
	_	why he is here and what					
		with. If feasible, have					
	_	n in his room where he is					
	at.						
	4. Plan ahead an	d if Resident is already					
		en at that time before he					
	goes back to his						
	30 12 2 3 <b>3</b> 10 1110						
	Interview on 6/1	3/14 at 2:15 p.m., with					
	the Administrato	or indicated "I was not					
	notified of Resid	lent # 53 losing his lower					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 27 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPI 06/13	LETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A 1023 N 2	DDRESS, CITY, STATE, ZIP COI 20TH ST ASTLE, IN 47362	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	notified the Soci investigative rep was notified." At Resident # 53 wo	oruary when his daughter al Services Director. An ort was done as soon as I dministrator indicated ould be placed on dental tal services visit next					
	Housekeeping D was not notified missing his lowe	30 p.m., interview with irector indicated no she Resident # 53 was r denture until February had been found in the					
	Resident/ Family by the Administrated Reside that resident is magnetic denture - fears that the trash - (been thought that they Resident has been services - on list to Follow- up dated reportedly refuse	14 at 2:45 p.m., of a Concern Form provided rator dated 2/10/14 nt # 53's daughter states assing his bottom hat he has thrown them in missing for a while - a would " turn up." In referred to dental to be seen tomorrow. In 2/27/14 Resident and the dentist when he he placed on the list for					
	or stolen items w Director of Nurs	50 p.m., Policy for lost vas provided by the ing indicated: Following investigation,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 28 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155089	B. WIN	G		06/13/	/2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAC	BE HOUSE OF NEV	VCASILE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	it shall be at disc						
		to replacement of lost or					
		ed upon individual					
	circumstances.						
	3.1-24(a)(3)						
F000441	483.65						
SS=D	INFECTION CON	TROL. PREVENT					
00 2	SPREAD, LINENS						
		stablish and maintain an					
		Program designed to					
	environment and to	nitary and comfortable					
		transmission of disease					
	and infection.						
	(a) Infection Contro						
	Control Program u	stablish an Infection					
		ontrols, and prevents					
	infections in the fa						
		procedures, such as					
		e applied to an individual					
	resident; and (3) Maintains a red	cord of incidents and					
		related to infections.					
	(b) Preventing Spr						
		ction Control Program resident needs isolation to					
		d of infection, the facility					
	must isolate the re	· · · · · · · · · · · · · · · · · · ·					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 29 of 33

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION  00	l ′	E SURVEY PLETED
		155089	A. BUILDING		06/13	3/2014
			B. WING	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIE	₹		3 N 20TH ST		
HERITAGE HOUSE OF NEW CASTLE				V CASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE PRIATE	COMPLETION
TAG			TAG	DEFICIENCY)		DATE
		st prohibit employees with disease or infected skin				
		t contact with residents or				
	their food, if direct	t contact will transmit the				
	disease.					
		st require staff to wash each direct resident contact				
		ashing is indicated by				
	accepted professi					
	(c) Linens					
		andle, store, process and o as to prevent the spread				
	of infection.	o do to prevent the opicad				
	Based on observ	ration, interview, and	F000441	Heritage House continues	to have	07/13/2014
	record review, the facility staff failed to			an established and will ma		
		s after removing a soiled		an Infection Control progra designed to provide a safe		
		for 1 of 1 residents		sanitary and comfortable	,	
	1	essing change, of 1		environment and to help pi	revent	
		et the criteria for pressure		the development and		
	ulcer. (Resident	•		transmission of disease an		
		, = 3)		infection.1.Staff will wash he when they change their glo		
	Findings include	<b>5</b> .		during a dressing change of		
	i manigs merado			resident #56.2. All other re		
	Resident #56's re	ecord was reviewed on		requiring a dressing chang		
		a.m. Diagnoses included		the potential to be affected		
		ited to, Multiple		Nursing staff will follow the on hand washing and dres		
	Sclerosis and pro	-		changes.3. Nursing staff w		
	Seletosis una pro	essare areer.		inserviced on hand washin		
	Resident #56's a	uarterly Minimum Data		dressing changes by 7/13/ Infection Control Nurse wil		
		essment dated 4/23/14,		randomly observe dressing		
	` ′	as totally dependent on 2		changes and hand washing		
		mobility and transfers.		continue to educate staff a	S	
	She did not wall	•		necessary. A log will be ke	pt.	
				Attachment #6.4. Administrator/DON or their		
		e required total assistance		designee will monitor 2 tim		
	•	lressing and personal		week for 3 months then 1 t		
	I hygiene. She ha	d a diagnosis of Multiple				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 30 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155089	B. WING			06/13/	/2014
NAME OF I	PROVIDER OR SUPPLIE	D.	<del>'</del> 1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	K		1023 N	20TH ST		
HERITA	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	week for 3 months. A report or		DATE
		n unhealed stage IV			findings will be given to the QA		
	pressure ulcer.				Committee and their		
		1 C D :1 + 1/56			recommendations followed.		
		rder for Resident #56					
		ndicated she would					
		dry dressing treatment to					
	her coccyx pres	sure ulcer 2 times a day.					
	A "Skin Condit	ion Report" for Resident					
		4, indicated she had a					
		a pressure ulcer measuring					
		eters) long, 3.3 cm wide,					
	`	o. The wound color was					
	_						
		nguineous (composed of					
	serum and bloo	a) drainage.					
	Resident #56 w	as observed receiving a					
	wet to dry dress	sing treatment to her					
	coccyx pressure	e ulcer on 6/10/14 at 2:33					
		ssisted by holding					
	-	her right side while RN					
		treatment. LPN #4 and					
	_	th wearing gloves. RN #4					
		I gauze that was packed in					
		the old dressing covering					
		were both wet with					
		s drainage. She changed					
		cleaned the wound using					
	_	vound cleanser, and a					
		hanged her gloves and					
	_	nd with sterile gauze wet					
	_	ine. She then placed					
		r the gauze packed in the					
		ound bed was red and					
	,,, ound. The WC	Jana Joa was roa una					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 31 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155089		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 06/13	LETED	
		10000	B. WING		DDRESS, CITY, STATE, ZIP CODE	30,10	
NAME OF PROVIDER OR SUPPLIER					20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	COMPLETION DATE
TAG		pproximately a half		TAG			DATE
	dollar size in dia						
	On 6/10/14 at 3:	05 p.m., RN #4 indicated					
		ned her hands after					
		evious dressing from					
		occyx wound during her					
		She indicated Resident					
		excessive drainage that					
	soilage for her.	ern for contamination or					
	soliage for her.						
	A Nurses Note d	ated 6/11/14 at 3:00					
		Resident #56's skin had					
	_	Her coccyx wound					
	measured 3.4 cm	long by 3.3 cm wide by					
	3.0 cm deep. Th	e wound base was red					
	with a moderate	amount of					
	_	drainage noted to the					
	dressing.						
	A "Dragging Cl	ean Technique" policy					
		ovided by the DON					
		sing) on 6/13/14 at 2:42					
	`	he following: "Purpose:					
		technique is used to					
	provide an appro	_					
	environment con	ductive of wound					
	_	ure: 1. Verify physician					
		y Resident. 2. Explain					
	. ^	sident and provide					
		h hands. Put on gloves.					
		d dressing and discard					
	into designated v	vaste receptacle. 5.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet

Page 32 of 33

PRINTED: 07/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED
	155089	B. WING		06/13/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
			20TH ST	
HERITAC	GE HOUSE OF NEW CASTLE	NEW C	ASTLE, IN 47362	
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Remove gloves, wash hands, and put on a			
	pair of clean gloves".			
	A "Dressing, Moist" policy and			
	procedure provided by the DON on			
	6/13/14 at 2:42 p.m., indicated the			
	following: Purpose: Moist dressings are			
	used to debride a wound and provide a			
	physiological environment conductive to			
	wound healing. Procedure: 1. Identify			
	Resident. 2. Explain procedure to			
	Resident and provide privacy. 3. Wash			
	hands. Put on gloves. 4. Remove			
	previous dressing; dispose of properly. 5.			
	Remove gloves; dispose of properly. 6.			
	Wash hands. Put on clean gloves".			
	wash hands. Fut on clean gloves			
	3.1-18(1)			
	J.1-10(1)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR5711

Facility ID: 000035

If continuation sheet Page 33 of 33